Reprinted
March 5, 1999

SENATE BILL No. 620

DIGEST OF SB 620 (Updated March 4, 1999 7:02 pm - DI 44)

Citations Affected: IC 27-8.

Synopsis: Indiana comprehensive health insurance association. Provides that the Indiana comprehensive health insurance association may borrow funds from the state or a financial institution to provide working capital. Provides that the rates for a given classification of insurance may be between 130% and 175% of the average premium rate for that class charged by the five carriers and health maintenance organizations with the largest premium volume in the state during the preceding calendar year so long as the median of the rates is 150%. Limits the total value of loss assessments to association members to the average of the sum of the total assessments plus the claims submitted to the state budget agency for the three most immediate fiscal years. Requires that the association, on a semi-annual basis, submit to the state budget agency claims for amounts necessary for performance of the association's functions that exceed the assessment limitation.

Effective: July 1, 1999.

Johnson, Kenley, Simpson, Mills

January 21, 1999, read first time and referred to Committee on Health and Provider Services.
February 18, 1999, amended, reported favorably — Do Pass; reassigned to Committee on Finance.
March 1, 1999, amended, reported favorably — Do Pass.
March 4, 1999, read second time, amended, ordered engrossed.

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First Regular Session 111th General Assembly (1999)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 1998 General Assembly.

SENATE BILL No. 620

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-10-2.1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 1999]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of seven (7) members whose principal residence is in Indiana selected as follows:

(1) Three (3) members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions, and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of

directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or

groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(15) Borrow funds from a financial institution or from the state to provide working capital for the operation of the association.

(f) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may not be **less than one hundred thirty percent (130%) or** more than one hundred ~~fifty~~ **seventy-five** percent ~~(150%)~~ **(175%)** of the average premium rate for that class charged by the five (5) carriers **and health maintenance organizations** with the largest premium volume in the state during the preceding calendar year. **However, the median of the rates for a given classification must be one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers and health maintenance organizations with the largest premium volume in the state during the preceding calendar year.** In determining the average rate of the five (5) largest carriers **and health maintenance organizations**, the rates charged by the carriers

and health maintenance organizations shall be actuarially adjusted to determine the rate that would have been charged for benefits identical to those issued by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. Any net loss shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association or any other equitable basis as may be provided in the plan of operation. For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided. In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. Net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner. **Beginning with the assessments made in fiscal year 2000, the total of the annual assessments to all members of the association may not exceed the average of the sum of the:**

(1) total assessments; plus

(2) claims submitted to the state budget agency under this subsection;

for the three (3) most immediate fiscal years. The association shall, on a semi-annual basis, submit to the state budget agency claims for payment of amounts that are necessary for performance of the association's functions and that exceed the assessment limitation contained in this subsection.

(h) The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and

the association shall have an annual audit of its operations by an independent certified public accountant.

(i) The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

(l) The association shall pay an agent's referral fee of twenty-five dollars ($25) to each insurance agent who refers an applicant to the association if that applicant is accepted.

(m) The association and the premium collected by the association shall be exempt from the premium tax, the gross income tax, the adjusted gross income tax, supplemental corporate net income, or any combination of these, or similar taxes upon revenues or income that may be imposed by the state.

(n) Members who after July 1, 1983, during any calendar year, have paid one (1) or more assessments levied under this chapter may either:

(1) take a credit against premium taxes, gross income taxes, adjusted gross income taxes, supplemental corporate net income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or

(2) any member insurer may include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

(o) The association shall provide for the option of monthly collection of premiums.

(p) A member of the association may appeal to the commissioner regarding the assessment made by the association to:

(1) defer the payment of the assessment for up to one (1) year;
(2) make assessment payments on a monthly or quarterly basis for cause; or
(3) reduce or suspend an assessment if the payment would cause the member's net worth or reserves to be less than required by statute.

COMMITTEE REPORT

Mr. President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 620, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 2, strike line 42.

Page 3, strike lines 1 through 2.

Page 3, line 3, strike "(6)" and insert "**(5)**".

Page 3, line 5, strike "(7)" and insert "**(6)**".

Page 4, between lines 21 and 22, begin a new line block indented and insert:

"**(15) Borrow funds from a financial institution or from the state to provide working capital for the operation of the association.**".

Page 4, line 28, strike "fifty" and insert "**seventy five**".

Page 4, line 29, strike "(150%)" and insert "**(175%)**".

Page 4, line 30, after "carriers" insert "**and health maintenance organizations**".

Page 4, line 32, after "largest carriers" insert "**and health maintenance organizations**".

Page 4, line 32, after "the carriers" insert "**and health maintenance organizations**".

Page 5, line 19, delete "The total value of assessments to members of the" and insert "**Beginning with the assessments made in fiscal year 2000, the total of the annual assessments to all members of the association may not exceed the average of the total assessments for the three (3) most immediate fiscal years. The association shall, on a semi-annual basis, submit to the state budget agency claims for payment of amounts that are necessary for performance of the association's functions and that exceed the assessment limitation contained in this subsection.**".

Page 5, delete lines 20 through 24.

Page 6, after line 24, begin a new paragraph and insert:

"**(p) A member of the association may appeal to the commissioner regarding the assessment made by the association to:**

(1) defer the payment of the assessment for up to one (1) year;

(2) make assessment payments on a monthly or quarterly basis for cause; or

(3) reduce or suspend an assessment if the payment would cause the member's net worth or reserves to be less than required by statute.".

and when so amended that said bill do pass and be reassigned to the Senate Committee on Finance.

(Reference is to SB 620 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 9, Nays 0.

COMMITTEE REPORT

Mr. President: The Senate Committee on Finance, to which was referred Senate Bill No. 620, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 5, line 27, before "total" insert "**sum of the:**

(1)".

Page 5, line 27, after "assessments" insert "**; plus**

(2) claims submitted to the state budget agency under this subsection;".

Page 5, line 27, before "for" begin a new line blocked left.

and when so amended that said bill do pass.

(Reference is to SB 620 as printed February 19, 1999.)

BORST, Chairperson

Committee Vote: Yeas 15, Nays 0.

SENATE MOTION

Mr. President: I move that Senate Bill 620 be amended to read as follows:

Page 2, reset in roman line 42.

Page 3, reset in roman lines 1 through 2.

Page 3, line 3, reset in roman "(6)".

Page 3, line 3, delete "(5)".

Page 3, line 5, reset in roman "(7)".

Page 3, line 5, delete "(6)".

Page 4, line 31, after "be" insert "**less than one hundred thirty percent (130%) or**".

Page 4, line 35, after "." insert "**However, the median of the rates for a given classification must be one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers and health maintenance organizations with the largest premium volume in the state during the preceding calendar year.**".

(Reference is to SB 620 as printed March 2, 1999.)

JOHNSON